DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey and complaint investigations (#35073, #35894 and #36085), were conducted from 5/4/15 through 5/6/15, at Unicoi County Nursing Home. Deficiencies were cited in relation to complaint investigations (#35073 and #35894), and no deficiencies were cited related to complaint (#36085), under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	**The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.**	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent	F 203	1. Resident #61 is no longer a resident at the facility. 2. On 5/27/15 and audit of all residents who were transferred/discharged for the previous 30 days was conducted by the Social Worker to ensure there was an appropriate written notice of transfer/discharge given and that it was documented in the record. No other residents were found out of compliance with transfer/discharge notices. 3. By 6/8/15, Registered Nurses, Licensed Practical Nurses, and Social Service will be in-serviced by the Director of Nursing on ensuring that residents who are transferred/discharged are given appropriate transfer/discharge notice and it is documented in their record. The Social Worker and/or Nursing Ward Clerk will conduct random audits weekly for 12 weeks. If 100% compliance is not obtained, then random audits will continue for an additional 4 weeks, until compliance is obtained.	6/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
Mark deFluiter	Administrator	7/21/15 5/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 203	Continued From page 1 medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on review of the facility policy "Transfer/Discharges", medical record review and interview, the facility failed to provide provide the family and or the resident with written notice of the discharge that included:Reason for transfer/discharge; he effective date of the transfer or discharge; the location to which the resident was transferred or discharged; right of appeal; and how to notify the ombudsman (name, address, and telephone number), prior to discharge from the facility for 1 resident (#61) of 27 residents reviewed.	F 203	4. Results of audits will be reported monthly by the Social Worker to the Performance Improvement committee (Administrator, D.O.N. Medical Director, Pharmacy Consultant, Dietitian, Social Worker, MDS Coordinator, & Activity Director) for 3 months to evaluate findings and amend plan as necessary.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 203	Continued From page 2 The findings included: Review of the facility policy "Transfer/Discharges" revealed the notification to the resident or family should include: Reason for transfer/discharge; the right of appeal; and how to notify the ombudsman (name, address, and telephone number), Medical record review revealed Resident #81 was admitted to the facility on 12/29/14 with diagnoses including Dementia, Atrial Fibrillation, Right Hip Fracture, Abnormal Gait, GI Bleed, History of DVT, Bilateral Carotid Stenosis, Renal Failure, Osteoporosis, and Dysphagia. Medical record review of the Orders and Progress Notes dated 3/5/15 at 3:00 PM revealed "...Transfer to...[local nursing facility] cont [continue] current medications..." Medical record review of the Free Text Charting Assessment dated 3/4/2015 at 7:28 PM by Minimum Data Set (MDS) Coordinator revealed " ...I inform my DON [Director of Nursing]...and she instructed me to call [resident's] family and let them know they needed to come and get her that we could not keep her here and her being so aggressive and violent toward the other residents and staff...I called her...and explained what had happened...I went into detail and explained that we have 44 other residents that we have to keep safe and protect and with her acting out like that we could not let her stay here and he stated he understood and agreed that the other resident could not be put at risk of her possibly harming them...He arrived approx. 1 hour after or phone conversation and asked if it would be ok for her to stay here tonight because he did not have a car	F 203		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 203	Continued From page 3 and his...didn't get off work until late tonight. The [DON]agreed that this would be ok. I explained in detail that she would be going home with home health and that medications would be sent the pharmacy of choice at time of d/c..." Interview with the MDS Coordinator on 5/5/15 at 2:35PM in the activity office revealed the MDS Coordinator is responsible for discharging residents from the facility. Continued interview confirmed the facility failed to provide a written notice of the discharge to the resident and or family prior to the time of discharge. Interview with the Director of Nursing (DON) on 5/5/2015 at 3:20 PM in the activity office confirmed the facility failed to provide the family and or the resident with written notice of the discharge that included: Reason for transfer/discharge; the effective date of the transfer or discharge; the right of appeal; and how to notify the ombudsman (name, address, and telephone number), prior to discharge from the facility.	F 203		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the	F 204		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 4 transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on review of the facility policy "Transfer/Discharges", medical record review and interview, the facility failed to provide provide the resident with sufficient preparation and orientation to ensure safe and orderly transfer from the facility, for 1 resident (#61) of 27 residents reviewed. The findings included: Review of the facility policy "Transfer/Discharges" revealed "...Orientation: The resident shall receive sufficient preparation and orientation to ensure safe and orderly transfer from the facility..." Medical record review revealed Resident #61 was admitted to the facility on 12/29/14 with diagnoses including Dementia, Atrial Fibrillation, Right Hip Fracture, Abnormal Gait, GI Bleed, History of DVT, Bilateral Carotid Stenosis, Renal Failure, Osteoporosis, and Dysphagia. Medical record review of the Orders and Progress Notes dated 3/5/15 at 3:00 PM revealed "...Transfer to...[local nursing facility] cont [continue] current medications..." Medical record review of the Free Text Charting Assessment dated 3/4/2015 at 7:28 PM by Minimum Data Set (MDS) Coordinator revealed " ...I inform my DON [Director of Nursing]...and she instructed me to call [resident's] family and let them know they needed to come and get her that	F 204	1. Resident #61 is no longer a resident at the facility. 2. On 5/27/15 and audit of all residents who were transferred/discharged for the previous 30 days was conducted by the Social Worker to ensure there was an appropriate written notice of transfer/discharge given and that it was documented in the record. No other residents were found out of compliance with transfer/discharge notices. 3. By 6/8/15, Registered Nurses, Licensed Practical Nurses, and Social Service will be in-serviced by the Director of Nursing on ensuring that residents who are transferred/discharged are given appropriate transfer/discharge notice and it is documented in their record. The Social Worker and/or Nursing Ward Clerk will conduct random audits weekly for 12 weeks. If 100% compliance is not obtained, then random audits will continue for an additional 4 weeks, until compliance is obtained. 4. Results of audits will be reported monthly by the Social Worker to the Performance Improvement committee (Administrator, D.O.N. Medical Director, Pharmacy Consultant, Dietitian, Social Worker, MDS Coordinator, & Activity Director) for 3 months to evaluate findings and amend plan as necessary.	6/8/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 5 we could not keep her here and her being so aggressive and violent toward the other residents and staff...I called her...and explained what had happened...I went into detail and explained that we have 44 other residents that we have to keep safe and protect and with her acting out like that we could not let her stay here and he stated he understood and agreed that the other resident could not be put at risk of her possibly harming them...He arrived approx. 1 hour after or phone conversation and asked if it would be ok for her to stay here tonight because he did not have a car and his...didn't get off work until late tonight. The [DON]agreed that this would be ok. I explained in detail that she would be going home with home health and that medications would be sent the pharmacy of choice at time of d/c..." Interview with the MDS Coordinator on 5/5/15 at 2:35PM in the activity office revealed the MDS Coordinator is responsible for discharging residents from the facility. Continued interview confirmed the facility had failed to provide sufficient preparation and orientation to the resident to ensure safe and orderly transfer prior to discharge. Interview with the Director of Nursing (DON) on 5/5/2015 at 3:20 PM in the activity office confirmed the facility had failed to provide sufficient preparation and orientation to the resident to ensure safe and orderly transfer prior to discharge.	F 204		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure supervision of a Resident during bathing for 1 resident (#70) of 30 residents reviewed. The findings included: Medical record review revealed Resident #70 was admitted to the facility on 5/3/14, with diagnoses including Recurrent Pneumonia, Urinary Tract Infections, Dementia, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Disease. Medical record review of a Nurse's Note dated 9/20/14 revealed "...CNA [Certified Nursing Assistant] was giving resident a bed bath and turned resident and resident rolled out of bed landing on her knees. She received a skin tear on both knees and right elbow...Daughter and MD [Medical Doctor] notified. Daughter asked if she wanted to send resident to ER [Emergency Department]. She told this nurse not right now..." Medical record review of a Daily Progress Note dated 9/23/14 revealed "...Patient with fall causing multiple abrasions worst being L [left] knee also has candidacies in mouth daughter request that I see her...pupils reactive but sluggish...Plan send to ER for head exam due to fall...wound care cleanse areas with wound cleanser apply	F 323	**Free of Accident Hazards/Supervision/Devices** 1. Resident #70 transferred to the hospital on 11/1/14 and did not return to this facility. 2. Under the supervision of the Director of Nurses it was determined that all residents are at risk for accidents relating to bathing. Residents will be assessed for needs and safety prior to bathing and appropriate measures will be applied. To be completed by 5/29/15. 3. To enhance currently compliant operations and under the direction of the Director of Nurses, by June 8, 2015 will complete in-service training for appropriate supervision, safety and addressing residents individually for special needs. In-services began May 26, 2105 and continued through each shift with each nursing employee scheduled until June 8, 2015. All employees not scheduled will be	6/8/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 Bactroban [Antibiotic] cover with Vaseline gauze 2 x 2's wrap with kerlix [type of guaze]...Diflucan [antibiotic]...QD [every day]..." Medical record review of a hospital Teleradiology Preliminary Report dated 9/23/14 revealed "...CT of head...no acute finding...no fracture..." Continued review of a Right knee and Right elbow x-ray revealed "...no fracture..." Review of the hospital Physician discharge order dated 9/23/14 revealed "...may return to NH [nursing home]..." Interview with CNA #1 on 5/6/15 at 8:10 AM by phone revealed, "...I had resident put hand on bed side rail and went to get linens from side of bed and noticed resident rolled out of bed..." Interview with Nurse Practitioner [NP] #1 on 5/6/15 at 8:55 AM in the Director of Nursing [DON] office revealed the NP was asked to see the Resident by Resident daughter on 9/23/14 and sent out as Progress Note stated due to resident assessment. Interview revealed Resident had very thin skin and was prone to skin tears and was in a declining state when entered the building in May and both NP and Physician asked family to suggest hospice, which the family declined. Continued interview and medical record review of the hospital ER records revealed the Resident was negative for any fractures. Interview with the DON on 5/6/15 at 7:45 AM, in the DON office confirmed the facility failed to ensure adequate supervision during bathing resulting in a fall.	F 323	called. New nursing employees receive the training as part of their new employee orientation. Any contracted nursing staff receive the appropriate training as part of the orientation to our building's operations. Beginning 5/25/15, two (2) direct care observations related to bed bathing residents (only 2 residents currently receive bed baths) will be conducted weekly for 12 weeks by the D.O.N. and/or RN Shift Leader and/or MDS Coordinator. These observations will ensure residents are being properly supervised during bed baths to prevent accidents and to ensure Care Plans are being reviewed and followed appropriately. Any safety issues identified will be immediately addressed with the involved team member. If 100% compliance is not obtained, then direct care observations will continue for an additional 4 weeks, until compliance is obtained. 4. The results of these observations will be presented by the D.O.N. and/or MDS coordinator to the monthly Performance Improvement committee (Administrator, D.O.N. Medical Director, Pharmacy Consultant, Dietitian, Social Worker, MDS Coordinator, & Activity Director) for 3 months to evaluate findings and amend plan as necessary.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 8 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assure medications were administered as ordered for 1 Resident (#70) of 30 residents reviewed. The findings included: Medical record review revealed Resident #70 was admitted to the facility on 5/30/14, with diagnoses including Recurrent Pneumonia, Urinary Tract Infections, Dementia, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Disease. Medical record review of a Daily Progress Note	F 425	**Pharmaceutical Services** 1. Resident #70 received antibiotic medications on 11/1/14. Resident #70 transferred to the hospital later that day on 11/1/14 and did not return to this facility. 2. All residents who receive new antibiotic orders are at risk for being affected by the same deficient practice. When this event was noted on 11/1/14, all resident records were audited by the Director of Nurses to ensure antibiotics were given as ordered. No other issues were noted. 3. The Director of Nurses re-educated Licensed Nurses on ensuring antibiotic medications are received, administered, and documented in a timely manner. Completion Date: 6/8/2015. Following the 11/1/14 incident, a Quality Assurance program was implemented by the Director of Nurses to monitor antibiotic orders and their timely administration. Licensed Nurse Shift leaders will perform medication audits on all residents receiving new antibiotic	6/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	109 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 9 dated 10/30/14 revealed "...Patient with S/S [signs and symptoms] of cold versus URI [upper respiratory infection] has low grade fever nasal congestion sore throat will assess...Plan...Azithromycin [antibiotic] 250 mg [milligrams] for 5 days...Vancomycin [antibiotic]...for 7 days..." Medical record review of a Physician order dated 10/30/14 revealed "...Azithromycin...for 5 days...Vancomycin for 7 days..." Medical record review of the Residents Medication Administration Record [MAR] for October 2014 and November 2014 revealed no documentation the medications had been administered. Interview and medical record review of a Nurse's note dated 11/1/14 with Registered Nurse [RN] #1 on 5/6/15 at 7:40 AM, in the Director of Nursing [DON] office revealed "...Patient lying in bed. Alert and confused at times. Able to make needs known. Started on Antibiotics..." Continued interview revealed the RN #1 noticed antibiotics Vancomycin and Azithromycin had not been administered as ordered on 11/1/14 and asked Licensed Practical Nurse [LPN] #1 to obtain and administer medications. Interview with LPN #1 on 5/6/15 at 11:03 AM by phone revealed the LPN obtained and started the medications on 11/1/14. Interview with the DON and medical record review of the Resident MAR's on 5/6/15 at 11:40 AM, in the DON office confirmed the medications (antibiotics Vancomycin and Azithromycin) had not been obtained or administered until 11/1/14.	F 425	medication orders. Audits began on 6/1/15 and will continue for 12 weeks. Any issues identified will be immediately addressed. If 100% compliance is not obtained, then audits will continue for an additional 4 weeks, until compliance is obtained. 4. The D.O.N. will submit the results to the monthly Performance Improvement committee (Administrator, D.O.N. Medical Director, Pharmacy Consultant, Dietitian, Social Worker, MDS Coordinator, & Activity Director). Starting with the June meeting, they will review results to evaluate findings and amend plan as necessary.	